I will leave it to the reader's discretion as to whether or not to include all or part of the additional 79 deaths in the "denominator."

I also would like to point out that the total number of patients involved in the study is a relatively small group as compared with other studies, and I am not sure that the differences are statistically significant. However, I would like to point out that the Seattle experience has suggested that when CPR is initiated by a trained bystander, nearly 40 percent of the patients will survive to leave the hospital alive.

In any event, it is still my contention that these criticisms do not alter the conclusions of the paper. In addition, I still feel that the paper shows that aggressive cardiopulmonary resuscitation will result in a significant number of survivors and that programs to implement effective CPR in rural areas and smaller hospitals are beneficial.

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Local Physicians, PSRO's and HSA's

TO THE EDITOR: The editorial in the April issue on Health Systems Agencies (HSA's) and local physicians was pertinent, but I don't think that it fully explained physician input in the planning process.

The editorial stated that "The omission, almost to the point of exclusion, of a significant presence of practicing physicians at each level of planning and decision making under this law seems to be a flaw which may prove serious and could even be fatal." And further, it said "Physicians have been assigned a peripheral rather than a central role."

What the editorial failed to mention was that physicians are involved all the way on Professional Standards Review Organization boards. Furthermore, by federal request we do have a memorandum of understanding with the HSA's. What does this mean?

It means that we can and will divulge nonconfidential data to HSA's to help them in their planning process. For example, data can be collected on computerized axial tomography (CAT) scanners as to their overutilization or underutilization. In addition, data can be collected as to whether our physicians thought the tests were better on the CAT scan or with use of ultrasound. Similarly, data could be developed regarding intensive care units, coronary care units, neonatal care and emergency rooms.

The skilled nursing facility has become a problem because of the paucity of beds—primarily because of the low Medi-Cal payments. Data could be accumulated to show whether this, in turn, causes more money to be wasted on acute hospital beds.

Of interest is the fact that in our HSA-PSRO community, there is a PSRO slot on the HSA board.

For the above reasons, I think that full participation by physicians in their PSRO is the only way to balance the consumer-dominated HSA.

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A New Dimension to Medicine

TO THE EDITOR: I was pleased to read the editorial in the April issue ("Health Systems Agencies and Local Physicians") urging increased physician involvement with health systems agencies (HSA's). I have been intimately involved with the local agency in my area but have found it distressingly frustrating when it comes to alerting local physicians that it is to their advantage to be involved from the initial stages with any such project. When physician involvement is present it is usually in reaction to a proposed plan of action—a tactic that, more often than not, is late and often has little success in amending the proposal. It is like the proverbial closing of the barn door after the horse has bolted.

Lest the editorial provoke an outburst of enthusiasm, let me inject a note of caution. The work can be pure drudgery most times; there is nothing glamorous about it. As the editorial noted it can often be wearing, time consuming and frustrating. Intelligent, diligent, nonself-serving input from physicians, however, can be significant and will often be welcomed.

There is a new dimension to medicine and this involves becoming more active and acquainted with legislation affecting the future of medicine. This means a definite commitment in time and effort. This could be done individually or in conjunction with the efforts of the local county medical society.

An aggressive leadership role has to be assumed by physicians. Participation in HSA activities need

not be limited to the governing body. There are multiple avenues for participation: serving on sub-area advisory councils, task forces and committees, or attending meetings as observers. This allows physicians to become part of the decision-making process that could finally achieve a mutually agreeable solution.

The recommendations of health planning agencies can have a significant impact on health care services in many communities. At present the HSA's monitor and regulate all major expansion programs within the health care system so that costly duplication of services can be avoided while necessary services are maintained. Eventually they will assume responsibility for reviewing the appropriateness of existing health care services for their respective areas.

Local HSA's respond to local conditions and at present are controlled by the local community. Physicians have an enormous stake in seeing that they succeed because, as Dr. John Freymann—the President of the National Fund for Medical Education and himself a physician—has noted, providers have the most to lose if these local agencies fail.[1] The alternative to provider inertia and local agency failure would be monolithic control of the entire health care system from Washington.

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REFERENCE

1. Freymann JG: Priorities in the organization of medical practice. Bull New York Acad Med 54:23-36, Jan 1978

Psychogenic Rheumatism

TO THE EDITOR: Dr. Michael Reynolds' excellent article on psychogenic rheumatism in the April issue again reminds us that musculoskeletal symptoms can be a somatic expression of emotional problems.

However, I would disagree with his statement that the distinction of psychogenic from organic disease "should not be difficult." The concept that many of these symptoms "fail to correspond to patterns of organic disorders" implies that the patterns of organic disorder are all clearly and completely understood at this time. I do not feel that this is an accurate conclusion. I agree with Dr. Reynolds that the diagnosis of rheumatoid arthritis and its variants is often used indiscriminantly, yet am concerned that the concept of psychogenic rheumatism may not also become overused and abused. It is soothing, unfortunately, to physicians to label illnesses as idiopathic or functional rather than to admit the limitation of current diagnostic methods. This is dangerous, not only because of the social implications for the patient, but also because it tends to decrease a doctor's diagnostic alertness to newer patterns of organic disorder and to those that await discovery. This was well expressed by Jean Marie Charcot (1825-1893) who said "In the last analysis, we see only what we have been taught to see. We eliminate and ignore everything that is not part of our prejudice."

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Of Pediatrics and Geriatrics

TO THE EDITOR: Dr. Alex Comfort's commentary "Geriatrics—The Missing Discipline?" (West J Med 128:257-259, Mar 1978) and his numerous contributions in similar vein, prompt me to put on paper thoughts I have had for some time now.

I agree that medicine (and surgery) of the aged is different than for adults, just as pediatrics is different. Indeed pediatrics is more related to geriatrics (and vice versa) than either is to adult medicine. As far as these two specialties go, it is true that certain diseases are more or less confined to one or other extreme of life. But there are many that afflict both age groups in similar manner. Examples are pneumonia, electrolyte disturbances, metabolic diseases and acute conditions of the abdomen, to name a few. Furthermore, there is no reason why one medical specialist could not become expert at those conditions which are common to both groups, as well as congenital and degenerative diseases which afflict pediatric and geriatric patients respectively.

The presentation of major disorders becomes increasingly nonspecific at both extremes of age. Furthermore, in childhood as well as in old age, most people are "well" despite minor continuing conditions; as Hodkinson, quoted by Comfort, says, a common syndrome in the elderly, is the equivalent of "failure to thrive" in pediatrics.

Another great similarity between the two disciplines is the dose range of, and the response to, commonly used medications as well as the complications of these medications.

With the dwindling of the pediatric population and the parri pasu increment in the ranks of the elderly, a marriage between the two disciplines